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Case Report

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Nausea and Vomiting: More than Just A GI Case

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Background

Nausea and vomiting are common presenting complaints; patients usually receive antiemetics and are discharged once able to tolerate oral intake. Etiology is usually unknown. Sometimes, diagnosis requires a more thorough workup, and treatment is not always gastroenterology (GI)–related.

Case Report

A 37-year-old Spanish-speaking female with history of Hashimoto's thyroiditis presented to the emergency department with intractable nausea and vomiting, inability to tolerate oral intake, and 35-pound weight loss. A thyroid study at her primary care provider was significant for elevated thyroglobulin and TPO antibody; thyroid ultrasound was normal. She was started on levothyroxine with no improvement in symptoms. She was referred to GI and started a proton pump inhibitor (PPI), again with no improvement. Computed tomography (CT) of her abdomen/pelvis was unremarkable.

She managed symptoms with outpatient intravenous normal saline infusion and B12 shots, but symptoms progressed to where she required assistance for activities of daily living. At presentation, she was hypotensive (102/55 mmHg) with signs of dehydration. Labs were remarkable for serum sodium of 132 mmol/L and serum potassium of 4.6 mmol/L. Given significant weight loss, we pursued cancer workup and involved inpatient GI. She underwent an upper GI endoscopy with biopsies, ultrasonography of the abdomen, pelvic exam, and another CT abdomen/pelvis; all were unremarkable. One day, a family member noted marked hyperpigmentation of the skin; she was becoming persistently hypotensive and no longer responding to fluids. This prompted a morning cortisol level measuring <0.4 mcg/dL (normal range: 8.7-22.4 mcg/dL) and adrenocorticotrophic hormone (ACTH) level of 964 pg/mL (6-50 pg/mL), confirming primary adrenal insufficiency. Endocrine was consulted and she was initiated on hydrocortisone and fludrocortisone; her symptoms resolved [1,2].

Discussion

The most common physical exam presentation of primary adrenal insufficiency is hyperpigmentation, then GI symptoms: 40% of cases have nausea and vomiting. Hyponatremia and hyperkalemia are usually seen but hyperkalemia was not present in our case, likely as a result of vomiting. Tuberculosis and other infections are the most common causes of primary adrenal insufficiency in middle-/low-income countries, while autoimmune diseases are the most common in high income countries. Our patient had normal adrenal glands, negative interferon gamma, and negative cancer screening, but she did have a history of thyroid antibodies making autoimmune disease the cause of her adrenal insufficiency.

Conclusion

In patients with unexplained intractable nausea and vomiting, fatigue, and weight loss, non-GI etiologies such as adrenal insufficiency should be considered once common causes are ruled out.

References

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